STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for Recertification and State Licensure Survey. Survey Dates: May 13, 14, 15, 16 & 17, 2013 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 Survey Team: Lora Swanson, RN TC Brenda Meredith, RN Deb Kammeyer, RN Julie Wagoner, RN Census bed type: SNF: 35 SNF/NF: 119 Total: 154 Census payor type: Medicare: 20 Medicaid: 100 Other: 34 Total: 154 Quality Review completed on May 24, 2013, by Brenda Meredith, R.N.	F000000	Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Recertification and State Licensure Survey conducted on 5/17/2013. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This Plan of Correction is being submitted solely because it is required by State and Federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure that 4 of 4 residents reviewed for discharge from Medicare services received notification in a timely manner. (Resident # 206, Resident #88, Resident #23 and Resident #109) Finding includes: On 5/15/13 at 9:00 A.M., record review for Resident #206, Resident # 88 and Resident # 23 indicated no copies of the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) were in the chart. The Form No. CMS-10055 entitled Skilled Nursing Facility Advance Beneficiary Notice for Resident #109 indicated, "Last covered day 11/3/12." The Date of Notice was 11/1/12. On the bottom left corner of the form it was indicated that the SNFABN was mailed to the POA (Power of Attorney) on 11/1/12. The form was not signed. On 5/15/13 at 10:00 A.M., review of current "Preparing a Resident for Transfer or Discharge Responsibilities of the Business Office" policy	F000156	**F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES** Facility will continue to provide notices as required by F156 including, but not limited to, Advance Beneficiary Notices in a timely manner. **Corrective Actions:** Residents #206, #88, #23, and #109 all were notified that they were being discharged from Medicare services before the survey commenced. **How Others Identified:** All residents receiving Medicare services, through Medicare Part A or Medicare Part B, have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Members of the facility's Medicare IDT Team, which includes the Business Office Manager, Rehab Director, Executive Director, and Social Services Director, have all been trained on the requirements associated with giving proper advanced notice to residents who are to be discharged from Medicare services. Verbal notification of Medicare non-coverage will be documented on the ABN itself and the form forwarded for signature. All attempts at notification will be documented. Residents and their responsible parties will be contacted 7-10 days in advance of the end of their projected Medicare coverage to determine	06/16/2013

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	received from the DON (Director of Nursing) indicated, "...As appropriate, the business office will issue an advanced beneficiary notice (ABN) in accordance with Medicare policy and rules...." On 5/15/13 at 10:30 A.M., review of current "Notice of Medicare Provider Non-Coverage," "The Generic Notice" CMS-10123 indicated, "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities (SNF's)...not later than 2 days before the termination of services...." On 5/15/13 at 9:10 A.M., an interview with Business Office Manager indicated, she could not find a copy of the ABN (Advanced Beneficiary Notice) in the chart for Resident #206, Resident #88 and Resident #23. The Office Manager further indicated that the Receptionist mails the ABN to the resident's family members to sign and return the forms. If the receptionist doesn't get the signed form back then the facility has no copy of the ABN in the chart. 3.1-4(a)		if the Advance Beneficiary Notice (ABN) should be mailed, faxed, or if the resident/POA would prefer it to be hand-delivered while they are at the facility. If the ABN needs to be mailed, it will be mailed as soon as possible so as to allow for it to be returned before Medicare coverage ceases. **Monitoring:** Medicare IDT Team has implemented a new ABN tracking tool to ensure that ABNs are issued and return within the appropriate timeframes. This tracking tool will be reviewed three times per week by the IDT Team for the first three months and then weekly thereafter for the next nine months to ensure compliance. Once completed, the tracking tools will be reviewed by the facility's QAPI Committee monthly for the next twelve months.	

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F000225	**F225 INVESTIGATE/REPORT**	06/16/2013

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	interviews, the facility failed to ensure 1 of 3 investigations involving 1 resident (Resident #155) regarding allegations of abuse were thoroughly investigated and reported timely. Finding includes: 1. Review of an allegation of abuse, on 05/17/13 at 10:45 A.M. regarding an incident which occurred between CNA #17 and Resident #155, indicated the incident had occurred on 10/25/13 sometime in the morning. The actual time of the incident or time the facility was made aware of the incident was not documented in the investigative documentation provided by the Director of Nursing. The allegation was not reported to the Department of Health until 10/26/12 at 3:38 P.M. over 24 hours later, by the DON . The DON indicated she did not report the allegation earlier because she was waiting to get in contact with the alleged perpetrator. There was no documentation in the investigation regarding when the Administrator, who was in the building was notified. However, the earliest documentation in the clinical record regarding the incident was made at 12:51 p.m. on 10/25/12 and the incident was not reported until		**ALLEGATIONS/INDIVIDUALS** Facility will continue to investigate all allegations of abuse thoroughly and report them timely. **Corrective Actions:** As noted in the 2567, the allegation was reported to ISDH the day after it was made. As reported to the surveyor during the facility's survey, the employee involved in the allegation was terminated the same day (10/26/12). **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Staff has been re-trained on abuse, how to identify it, and what their obligations are in reporting it. **Monitoring:** Facility has implemented an Abuse Allegation checklist, which tracks the time/date of the incident(s), the time/date it was reported to the appropriate authorities, the pieces necessary to complete an investigation (i.e. staff and resident interviews, etc.). Said checklist will be reviewed at morning meeting daily when there are outstanding allegations of abuse, with appropriate follow-up assigned to the appropriate parties. This checklist will be submitted to the facility's QAPI Committee for review and follow-up monthly for the next 12 months to ensure that allegations are handled appropriately.	

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	10/26/12 at 3:37 P.M. Interview, on 05/17/13 at 11:00 A.M. with Director of Nursing and the Administrator, indicated the Director of Nursing was out of the building at an inservice when the initial allegation was made. She indicated the Unit Manager documented the incident and notified her of the incident. The Administrator was in the building at the time of the allegation and indicated he was notified of the incident and although he made no documentation, he felt he was the one to ask the Social Service staff on 10/25/12 prior to 12:51 P.M., to talk with Resident #155. Both the Administrator and the Director of Nursing indicated Resident #155's husband had evidently called to report the incident but there was no statement from the resident's husband and no documentation in the resident's chart regarding the issue until the Social Service note, made on 10/25/13 at 12:51 P.M. regarding the incident. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to implement their policy for 1 of 3 investigations involving 1 resident (Resident #155) regarding allegations of abuse were thoroughly investigated and reported timely. Finding includes: 1. Review of an allegation of abuse, on 05/17/13 at 10:45 A.M., regarding an incident which occurred between CNA #17 and Resident #155, indicated the incident had occurred on 10/25/13 sometime in the morning. The actual time of the incident or time the facility was made aware of the incident was not documented in the investigative documentation provided by the Director of Nursing. Interview, on 05/17/13 at 11:00 A.M., with Director of Nursing and the Administrator, indicated the Director of Nursing was out of the building at an inservice when the initial allegation was made. She indicated the Unit	F000226	**F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES** Facility will continue to investigate all allegations of abuse thoroughly and report them timely. **Corrective Actions:** As noted in the 2567, the allegation was reported to ISDH the day after it was made. As reported to the surveyor during the facility's survey, the employee involved in the allegation was terminated the same day (10/26/12). **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Staff has been re-trained on abuse, how to identify it, and what their obligations are in reporting it. **Monitoring:** Facility has implemented an Abuse Allegation checklist, which tracks the time/date of the incident(s), the time/date it was reported to the appropriate authorities, the pieces necessary to complete an investigation (i.e. staff and resident interviews, etc.). Said checklist will be reviewed at morning meeting daily when there are outstanding allegations of abuse, with appropriate follow-up assigned to the appropriate	06/16/2013

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	manager documented the incident and notified her of the incident. The Administrator was in the building at the time of the allegation and indicated he was notified of the incident and although he made no documentation, he felt he was the one to ask the Social Service staff on 10/25/12 prior to 12:51 P.M.. to talk with Resident #155. Both the Administrator and the Director of Nursing indicated Resident #155's husband had evidently called to report the incident but there was no statement from the resident's husband and no documentation in the resident's chart regarding the issue until the Social Service note, made on 10/25/13 at 12:51 P.M. regarding the incident. The allegation was not reported to the Department of Health until 10/26/12 at 3:38 P.M. over 24 hours later, by the DON . The DON indicated she did not report the allegation earlier because she was waiting to get in contact with the alleged perpetrator. There was no documentation in the investigation regarding when the Administrator, who was in the building was notified. However, the earliest documentation in the clinical record regarding the incident was made at 12:51 p.m. on 10/25/12 and the		parties. This checklist will be submitted to the facility's QAPI Committee for review and follow-up monthly for the next 12 months to ensure that allegations are handled appropriately.	

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	incident was not reported until 10/26/12 at 3:37 P.M. 2. Review of the facility policy and procedure, titled "Reporting Abuse to Facility Management," revised in 2006, and indicated by the Director of Nursing, on 05/17/13 at 11:00 A.M., as the current policy, included the following: "...5. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, or his/her designee, will immediately (within twenty-four hours of the alleged incident) notify the following persons or agencies of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility; bathe local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. The Adult Protective Services; e. Law Enforcement officials; father Resident's Attending Physician; and gather Facility Medical Director.... " 3.1-28(a)			

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F000247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a notice of a roommate change was given for 1 of 24 residents who met the criteria. (Resident #26) Finding includes: 1. During an interview, conducted on 05/13/13 at 10:52 A.M., Resident #26 indicated she had recently had a roommate change and she was never told a new resident was going to be moving into her room. She indicated the new roommate had since passed away. The clinical record for Resident #26 was reviewed on 05/16/13 at 9:00 A.M. There was no documentation in the electronic chart or the paper chart for Resident #26 regarding notifying her of a new roommate. There was documentation regarding the death of both roommates and checking for grieving issues regarding their deaths with Resident #26. Interview on 05/16/13 at 10:07 A.M., with Social Service designee,	F000247	**F247 RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE** Facility will continue to provide residents notice before a room or roommate change. **Corrective Actions:** As noted in the 2567, resident #26 does not currently have a roommate as the roommate she received 2/22/13 expired. **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Staff has been trained on the requirement to notify residents of changes in room and/or roommate and the need for documentation indicating that such notification has been made. **Monitoring:** Social Services Department will audit the charts of residents having had a change in room and/or roommate to ensure that the notification is documented. These audits will occur 5 times/week x 3 months, then 3 times/week x 3 months, then weekly for six months. These findings will be submitted to the facility's QAPI Committee for review and follow-up. All findings will be discussed in the monthly QAPI Committee meeting for further system review as deemed appropriate by the committee.	06/16/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Employee #13, indicated the unit manager was to have informed Resident #26 of a new roommate change, but unfortunately there was no documentation regarding this issue. Employee #13 indicated Resident #26 had received a new roommate on 02/22/13. 3.1-3(v)(2)			

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	155689	A. BUILDING 00 B. WING	05/17/2013

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interviews, the facility failed to ensure care plans were developed for 1 of 10 residents reviewed for unnecessary medications regarding insomnia or depression. (Resident #207) In addition, the facility failed to ensure a care plan regarding hydration needs was developed for 1 of 2 residents reviewed for hydration needs. (Resident #47) Findings include: 1. The clinical record for Resident	F000279	**F279 DEVELOP COMPREHENSIVE CARE PLANS** The facility will continue to use the results of the (MDS) assessment to develop, review, and revise the resident's comprehensive care plan. **Corrective Actions:** Resident #207s care plans have been updated to reflect her diagnoses of insomnia and depression. Resident #47s care plans have been updated to include her hydration needs. Resident #47 has been provided with "the smaller glasses" to improve her ability to hydrate herself. Resident #47s C.N.A.	06/16/2013

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	#207 was reviewed on 05/16/13 at 10:45 A.M. The resident was admitted to the facility on 01/03/2013 with diagnosis, including but not limited to, s/p (status post) bacterial pneumonia, influenza, diabetes, hypertension, hypothyroidism, Alzheimer disease, dementia with behavioral disturbances, hypercholesterolemia, macular degeneration of retina, glaucoma, atrial fibrillation, hx (history) of Acute CVA (cerebral vascular accident). The resident's medication orders, current through May 2013, included orders for the antidepressant medications, Exelon 9.5 mg (milligrams)/24 hour patch and Trazadone 25 mg one tablet at bedtime. In addition, the resident was to receive Melatonin (a natural medication to assist with sleep) 3 mg at bedtime for insomnia. A pharmacy recommendation, dated 03/27/13, indicated the resident was receiving the Melatonin and the Trazadone medication for insomnia. The recommendation also indicated the resident had reported some signs and symptoms of depression. Interview with LPN #11, on 5/16/13 at 11:00 A.M., indicated the resident		Assignment Sheet has been updated to reflect the resident's desire to be provided with the "smaller glasses". **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** All Care Plans have been reviewed to ensure that they address all areas dictated by the resident's diagnoses, their physician's orders, and any items noted through the MDS/CAAs or other assessments completed specific to the resident. In the cases where those changes affect the care being provided by the facility's CNAs, the C.N.A. Assignment Sheets have been modified accordingly. New orders, 24 hour report, and changes in condition will be reviewed daily at morning meeting by IDT. Care plans and CNA assignment sheets will be updated to reflect the current identified needs, condition, and required care of the resident. Staff has been trained on Care Plans, the need to follow them, and the importance of them being updated, to reflect the resident's needs, condition, and required care. **Monitoring:** Unit Managers will audit charts on a unit other than their own to ensure that the Care Plans remain updated and reflective of the care being provided to the residents. Each Unit Manager will audit five charts/week for the first three	

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	was only being monitored for Hallucinations and had no care plan to address her insomnia and depression issues. 2. The clinical record for Resident #47 was reviewed on 5/17/13 at 1:30 P.M. Review of the Resident Nutrition Assessment completed on 4/9/13, indicated Resident #79 had fluid balance Risk factors of edema and required 2225-2670 ml(millimeters) of fluid per day. Review of the fluid intake record for 5/1/13 through 5/16/13 indicated the resident consumed a high of 2160 cc's (cubic centimeters) to a low of 240 cc's per day. Review of the Medication Administration Record (MAR) indicated no other intake of fluids were documented. The MAR indicated the resident received 60 mg (milligrams) of Lasix (a diuretic) daily. Review of the Care Plans for Resident #47 indicated the facility had not developed a care for adequate hydration for the resident. On 5/17/13 at 1:40 P.M., observation of the resident's water glass at the bedside indicated the resident had a large insulted water glass/container full of water. Resident #47 was interviewed at this time. She		months, then three charts/week for three months, then one chart/week for six months and document their findings. These findings will be submitted to the facility's QAPI Committee for review and follow-up.	

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	indicated the water glass was too large for her to use and this is the only water glass she has had today. She indicated she needed the smaller glasses. On 5/17 /13 at 1:45., R.N. #3 was interviewed. She indicated the night shift changes the water glasses and they were probably not aware that the resident needed the smaller glasses. On 5/17/13 at 2:30 P.M., the Director of Nursing was interviewed. She indicated she was aware of the lack of care plan for hydration. On 5/17/13 at 2:35 p.m., review of the policy titled, Resident Hydration and Prevention of Dehydration, dated "Revised April 2007," and presented by the DON as current, indicated "13. ...Interdisciplinary team will update care plan and document resident response to interventions until team agrees that fluid intake and relating factors are resolved." 3.1-35(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to follow physician's orders for 1 of 1 residents reviewed for dialysis needs (Resident #144) and 1 of 10 residents reviewed for unnecessary medications. (Resident #62). In addition the facility failed to follow a care plan regarding range of motion needs for 1 of 2 residents reviewed in a sample of 40 for range of motion needs. (Resident #136) Finding includes: 1. The clinical record for Resident #144 was reviewed on 05/15/13 at 11:00 A.M. Resident #144 was readmitted to the facility on 03/06/13, with diagnoses, including but not limited to,Chronic pyelonephritis, atreriovenous fistula, chronic kidney disease stage v, chronic glomerulonephirist with pathological kidney disease, hypertension, anxiety, adjustment disorder with depressed mood, epilepsy, mild intellectual disabilities, BPH (benign prostate hyperplasia), diabetes uncontrolled,	F000282	**F282 SERVICES PER QUALIFIED PERSONS/PER PLAN OF CARE** The facility will continue to provide or arrange for services provided by qualified persons in accordance with each resident's written plan of care. **Corrective Actions:** The C.N.A. Assignment Sheet for resident #136 has been updated to reflect the need for the resident to receive Range of Motion (ROM). Staff have been educated on ROM/splinting programs and documentation of ROM/splinting programs. Nursing Staff have been re-educated on the process of adding all lab orders to the lab calendar book and notifying the laboratory provider of all new orders. Nurses have been educated on the use of the dialysis communication form and post dialysis assessment with each dialysis treatment. Written counseling will be initiated with any failure to comply with this policy. **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Nurses have been in-serviced on Care Plans (as noted above under the response for F279) and the need for	06/16/2013

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	anemia, hyperpotassemia (sic). The May 2013 physician's orders for Resident #144 included orders for the resident to receive dialysis on Mondays, Wednesdays and Fridays. The orders also included an order to check the port daily to make sure dressing was intact and to do a post dialysis assessment on Mondays, Wednesdays, and Fridays. Interview with the Unit Manager for Cedars unit, LPN # 21, indicated the resident usually left for dialysis around 11:30 A.M. - noon and returned from his treatments around 4:30 P.M. The Assessments section of the electronic clinical record for Resident #144 included a post dialysis assessments, however, they were not consistently completed on the dates and times of the resident's dialysis treatments. Interview, on 05/16/13 at 2:00 P.M., with LPN #18 and #19, who occasionally worked with Resident #144 or had worked with other previous dialysis residents, indicated the post dialysis assessments were to be completed sometimes per shift and sometimes per day, but they were not necessarily instructed to complete the assessments at the time the resident returned from his dialysis treatments.		specific documentation for those residents receiving dialysis. Each Unit has a lab calendar book in which lab orders are tracked to ensure the labs are drawn and results have been obtained. All labs orders are reconciled monthly with the laboratory providers order list to ensure physician orders have been completed and remain current. **Monitoring:** As noted above under the response to F279, Unit Managers will audit charts on a unit other than their own to ensure that the Care Plans remain updated and reflective of the care being provided to the residents. Each Unit Manager will audit five charts/week for the first three months, then three charts/week for three months, then one chart/week for six months and document their findings. These findings will be submitted to the facility's QAPI Committee for review and follow-up. Dialysis communication and post-dialysis assessments will be audited three times/week by DON (or designee), with documented results forwarded to facility's QAPI for review and follow-up. Audits will continue for a period of twelve months, provided that facility has a resident receiving dialysis.	

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Review of the post dialysis assessments for May 01, 2013 - May 16, 2013, indicated only on 05/13/13, 05/06/13 and 05/03/13 had post dialysis assessments been completed at the time the resident actually returned from the facility. On 05/15/13 at 17:18 (5:18 P.M.), there was a post dialysis assessment in the progress notes. On 05/08/13 at 16:37(4:37 P.M.), there was a post dialysis assessment in the progress notes.

On 05/15/13 at 11:00 A.M., the Unit Manager, LPN # 21 indicated the resident had a "dialysis book" he took back and forth to the dialysis center. There top half of the assessment form the facility completed for the dialysis center prior to his treatments and the bottom half of the form the dialysis center completed for the facility prior to the resident's return. There was no place on the form for nursing staff to document a post dialysis assessment.

2. The clinical record for Resident #62 was reviewed on 05/15/13 at 2:30 P.M. Resident #62 was admitted to the facility on 10/12/07, and readmitted to the facility on 12/19/2011, with diagnoses, including

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	but not limited to, contracture of joints, dysphasia due to cerebrovascular disease, abnormal posture, weakness, hemiplegia due to Cerebral Vascular Accident, anemia, depressive disorder, hyperlipidemia, hypertension, chronic ischemic heart disease, chronic pain syndrome, hypertrophy prostate without ureter obstruction, constipation, diabetes, paralysis agitans, aphasia, vascular dementia with depressed mood, dementia without behaviors, disturbance of conduct- unspecified. Review of the medication orders, for May 2013, for Resident #62 included orders for the following medications to treat the resident's diabetes; Lantus and Humolog insulin and Metformin. In addition, there were physician's orders to check the resident's blood sugar levels twice a day and to obtain a Hemiglobin A1C blood glucose level) lab test every 6 months. The lab section of Resident #62's paper chart, reviewed on 05/16/13 at 1:30 P.M., indicated the most recent Hemoglobin AIC test result was dated 07/24/12. The resident's results at the time were noted to be elevated at 9.1. The normal range for the lab was between 5.2 - 6.1 mg/dl. Interview with RN #19, on 05/16/13 at			

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	1:30 P.M., indicated she had checked with the laboratory and the lab test, which should have been completed in January 2013, had been missed. The health care plans for Resident #62, current through May 2013, included the following plan: "Potential for complications r/t multiple chronic diagnoses:DM [Diabetes], Depression, Hyperlipidemia, HTN [hypertension], CAD [coronary artery disease], BPH [benign prostate hypertrophy], Parkinsons, Chronic pain, Gastroporesis, Stroke Lt [left]Hemiparesis, constipation, dementia. New Goal New Custom Goal Resident will remain free from complications r/t multiple chronic diagnoses through next review New Intervention New Custom Intervention Administer medications as ordered Lab work as ordered List of diagnoses will be reviewed and updated q [every] 90 days and as needed Notify MD of any s [signs] /sxs [symptoms] of complications r/t [related to]the multiple chronic diagnoses." 3. The clinical record of Resident #136 was reviewed on 5-15-13 at			

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	1:15 p.m. The resident's diagnoses included, but were not limited to: cerebravascular accident (CVA), hemiparesis affecting the nondominant side, joint pain, and contracture of joint-mulitple sites. On 5-15-13 at 1:25 p.m., the undated careplan was reviewed and indicated the resident had hemiplegia (paralysis)/hemiparesis(weakness) related to CVA. The interventions included, but were not limited to: pain management as needed, PT (physical therapy) evaluate/treat as ordered, "...range of motion [ROM] (active or passive) with am/pm care daily...." The goal was "... resident would maintain optimal status and quality of life within limitations imposed by the Hemiplegia/Hemiparesis affecting nondominant side through review date...." An interview with with RN #3, on 5-15-13 at 1:45 p.m., indicated the resident was admitted with contracture's of the shoulder and elbow and doesn't want to be touched or moved on the left side. RN #3 further indicated she doesn't do ROM to the resident's nondominant side. An observation of the resident, on 5-15-13 at 1:50 p.m., with RN #3			

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	indicated the resident had no left shoulder or elbow motion. The fingers on the left hand were able to move and were not contracted. RN#3 indicated the resident had no splint for her left hand. There were no contracture's observed in the right extremity. A review of the CNA worksheet, on 5-15-13 at 2:00 p.m., indicated there were no instructions to provide ROM with AM and PM care daily. On 5-16-13 at 8:40 a.m., the DON (Director of Nursing) indicated she had no documentation on the resident's daily ROM, hand splint, or therapy. A form titled "Reasons or Triggers to refer to Therapy" dated 10-5-12 was reviewed on 5-16-13 at 8:45 a.m. and indicated the resident was referred to physical therapy for "...Contracture/positioning issues...." and to occupational therapy for ..."Leaning, sliding from w/c [wheel chair]...." An interview with CNA #4, on 5-16-13 at 4:10 p.m., indicated she tried to lift the resident's arm on the left but the resident doesn't move her arm up and her elbow was "frozen." CNA#4			

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	indicated the resident was able to move her fingers on the left hand but CNA #4 doesn't do any ROM to them. An interview with CNA #5, on 5-16-13 at 4:12 p.m., indicated she tried to move the resident's left side when getting her ready for bed but the resident wasn't able to tolerate much movement. CNA #5 indicated she doesn't do ROM with the resident's p.m. care. On 5-16-13 at 3:35 p.m. a review of a policy titled, "Care Planning--Interdisciplinary Team," dated 2001 and revised in 2006. The "Purpose of Care Plan" indicated that each resident's Comprehensive Care Plan has been designed to: "...e. Identify the professional services that are responsible for each element of care; f. Aid in preventing or reducing declines in the resident's functional status an/or functional level...." 3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interviews, the facility failed to ensure post dialysis assessments were consistently completed timely for 1 of 1 residents reviewed who received dialysis treatments. (Resident #144) Finding includes: 1. The clinical record for Resident #144 was reviewed on 05/15/13 at 11:00 A.M. Resident #144 was readmitted to the facility on 03/06/13, with diagnoses, including but not limited to, chronic pyelonephritis, atreriovenous fistula, chronic kidney disease stage v, chronic glomerulonephirist with pathological kidney disease, hypertension, anxiety, adjustment disorder with depressed mood, epilepsy, mild intellectual disabilities, BPH (benign prostate hyperplasia), diabetes uncontrolled, anemia and hyperpotassemia (sic). The May 2013, physician's orders for Resident #144 included orders for the	F000309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** The facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **Corrective Actions:** Staff have been educated on the use of the dialysis communication form and post dialysis assessment with each dialysis treatment. Written counseling will be initiated with any failure to comply with this policy. **How Others Identified:** All residents receiving dialysis have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Nurses have been in-serviced on the need for specific documentation for those residents receiving dialysis. **Monitoring:** Dialysis communication and post-dialysis assessments will be audited three times/week by DON (or designee), with documented results forwarded to facility's	06/16/2013

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	resident to receive dialysis on Mondays, Wednesdays, and Fridays. The orders also included an order to check the port daily to make sure dressing was intact and to do a post dialysis assessment on Mondays, Wednesdays, and Fridays. The Assessments section of the electronic clinical record for Resident #144 included a post dialysis assessments, however, they were not consistently completed on the dates and times of the resident's dialysis treatments. Interview, on 05/16/13 at 2:00 P.M., with LPN #18 and #19, who occasionally worked with Resident #144 or had worked with other previous dialysis residents, indicated the post dialysis assessments were to be completed sometimes per shift and sometimes per day, but they were not necessarily instructed to complete the assessments at the time the resident returned from his dialysis treatments. Review of the post dialysis assessments for May 01, 2013 - May 16, 2013, indicated only on 05/13/13, 05/06/13 and 05/03/13 had post dialysis assessments been completed at the time the resident actually returned from the facility. On 05/15/13 at 17:18 (5:18 P.M.), there		QAPI for review and follow-up. Audits will continue for a period of twelve months, provided that facility has a resident receiving dialysis.	

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	was a post dialysis assessment in the progress notes. On 05/08/13 at 16:37 (5:37 P.M.), there was a post dialysis assessment in the progress notes. On 05/15/13 at 11:00 A.M., the Unit Manager, LPN #21 indicated the resident had a "dialysis book" he took back and forth to the dialysis center. There top half of the assessment form the facility completed for the dialysis center prior to his treatments and the bottom half of the form the dialysis center completed for the facility prior to the resident's return. There was no place on the form for nursing staff to document a post dialysis assessment. On 5/15/13 at 11:15 A.M., during an interview, the Unit Manager for Cedars unit, LPN # 21, indicated the resident usually left for dialysis around 11:30 A.M. - noon and returned from his treatments around 4:30 P.M. 3.1-37(a)			

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F000318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview, observation and record review the facility failed to provide range of motion for 1 of 2 residents reviewed for contracture with range of motion or splint device, in a sample of 40. (Resident #136) Finding includes: The clinical record of Resident #136 was reviewed on 5-15-13 at 1:15 p.m. The residents's diagnoses included, but were not limited to: cerebrovascular accident (CVA), hemiparesis affecting nondominant side, joint pain, and contracture of joint-multiple sites. On 5-15-13 at 1:25 p.m., a careplan was reviewed and indicated the resident had hemiplegia (paralysis)/hemiparesis (weakness) related to CVA. The interventions included but were not limited to: pain management, physical therapy as ordered and "... range of motion (active or passive) with am/pm care	F000318	**F318 INCREASE/PREVENT RANGE OF MOTION** Facility will continue to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. **Corrective Actions:** The C.N.A. Assignment Sheet for resident #136 has been updated to reflect the need for the resident to receive Range of Motion (ROM). **How Others Identified:** All residents with limited range of motion have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Nursing staff have been trained on the need to provide range of motion for residents with limited range of motion/contractures. All residents with limited range of motion/contractures have been identified. ROM programs have been established and will be documented when completed by staff. Care plans and CNA sheets have been updated to reflect the ROM program. Staff has been educated regarding documentation of ROM in the	06/16/2013

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	daily...." The goal for the resident was that she would maintain optimal status and quality of life within limitations imposed by the hemiparesis. During an interview on 5-15-13 at 1:45 p.m., RN #3 indicated the resident was admitted with the contracture's and doesn't want to be touched or moved on the left side. RN #3 further indicated she doesn't perform ROM on the resident. An observation of the resident on 5-15-13 at 1:50 p.m. with RN #3. RN#3 indicated the resident had no left shoulder motion or elbow motion. The fingers on the left hand were able to move indicating they were not fully contracted. RN #3 indicated the resident had no splint for her hand. A review of the CNA worksheet, on 5-15-13 at 2:00 p.m., indicated there no instructions to provide range of motion (ROM) with AM and PM care daily. During an interview on 5-16-13 at 8:40 a.m., the DON (Director of Nursing) indicated she had no documentation on the resident's ROM, splint usage, or therapy.		medical record. MDS staff will be responsible for establishing ROM program and informing staff of ROM program. **Monitoring:** Facility has implemented a Range of Motion/Splinting audit which tracks the residents with limited range of motion/contractures, contracture location, therapy involvement for contracture management, whether a ROM or splinting program is in place, reflection of the ROM or splinting program on the CNA sheet, inclusion of the ROM or splinting program on the care plans, whether the splint is in place (when applicable), staff awareness of program and ability to return demonstrate ROM or splinting program, and placement of documentation in medical record for ROM or splinting program. This audit will be completed weekly by MDS. This checklist will be submitted to the facility's QAPI Committee for review and follow-up monthly to ensure that residents with limited range of motion/contractures receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	

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	On 5-16-13 at 3:35 p.m. a review of a policy titled, "Care Planning--Interdisciplinary Team," dated 2001 and revised in 2006. "Purpose of Care Plan" indicated each resident's Comprehensive Care Plan has been designed to: "...f. Aid in preventing or reducing declines in the resident's functional status an/or functional level...." During an interview on 5-16-13 at 4:10 p.m., CNA #4 indicated she tried to lift the resident's arm on the left but the resident doesn't move her arm up and her elbow doesn't move at all. CNA #4 indicated the resident can move her fingers on the left hand but CNA #4 doesn't do any ROM to them. During an interview on 5-16-13 at 4:12 p.m., CNA #5 indicated she tried to move the resident's left side when getting her ready for bed but the resident wasn't able to tolerate much movement. CNA #5 further indicated she doesn't do ROM with the resident's p.m. care. 3.1-42(a)(2)			

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F000327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. 2. The clinical record for Resident #47 was reviewed on 5/17/13 at 1:30 P.M. Review of the Resident Nutrition Assessment completed on 4/9/13, indicated Resident #47 had fluid balance Risk factors of edema and required 2225-2670 ml(millimeters) of fluid per day. Review of the fluid intake record for 5/1/13 through 5/16/13 indicated the resident consumed a high of 2160 cc's (cubic centimeters) to a low of 240 cc's per day. Review of the Medication Administration Record (MAR) indicated no other intake of fluids were documented. The MAR indicated the resident received Lasix (a diuretic) 60 mg (milligrams) daily. Review of the Care Plans for Resident #47 indicated the facility had not developed a care for adequate hydration for the resident. On 5/17/13 at 1:40 P.M., observation of the resident's water glass at the bedside indicated the resident had a large insulted water glass/container full of water. Resident #47 was interviewed at this time. She indicated the water glass was too	F000327	**F327 SUFFICIENT FLUID TO MAINTAIN HYDRATION** The facility will continue to provide each resident with sufficient fluid intake to maintain proper hydration and health. **Corrective Actions:** Resident #47s care plans have been updated to include her hydration needs. Resident #47 has been provided with "the smaller glasses" to improve her ability to hydrate herself. Resident #47s C.N.A. Assignment Sheet has been updated to reflect the resident's desire to be provided with the "smaller glasses". **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Facility has adopted the American Dietetic Recommendation that elderly adults consume a minimum of 1500cc of fluid in a 24 hour period. Staff has been educated to encourage residents to consume 500cc of fluid at each meal. All fluids given at meals, between meals, with med pass, and as snacks or supplements will be recorded and totaled daily. Facility's Nutritional-at-Risk (NAR) Committee will review this report weekly. Residents taking a daily average of less than 1500cc	06/16/2013

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	large for her to use and this is the only water glass she has had today. She indicated she needed the smaller glasses. On 5/17 /13 at 1:45., R.N. #3 was interviewed. She indicated the night shift changes the water glasses and they were probably not aware that the resident needed the smaller glasses. On 5/17/13 at 2:35 p.m., review of the policy titled, Resident Hydration and Prevention of Dehydration, dated "Revised April 2007," and presented by the DON as current, indicated "7. Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care....13. ...Interdisciplinary team will update care plan and document resident response to interventions until team agrees that fluid intake and relating factors are resolved." 3.1-46(b) Based on observation, interview and record review, the facility failed to provide the recommended amount of fluid daily to maintain the residents		and residents who are determined by the Nutrition at Risk (NAR) Committee to have a fluid need which exceeds 1500cc will be placed on a nursing hydration program which will include offering extra fluids each shift while awake and assessment of hydration status. Facility's Nutritional-at-Risk (NAR) Committee will review to determine appropriate interventions to attain and maintain sufficient fluid intake. Residents who receive supplements and/or snacks that are fluid-based will have their documentation changed from "percent consumed" to "cc's consumed" so as to more accurately reflect how much fluid a resident is consuming on a daily/weekly basis. NAR will function as the Interdisciplinary Team referenced in the 2567, page 25, and will "update (the) care plan and document resident response to interventions until team agrees that fluid intake and relating factors are resolved." **Monitoring:** NAR Meeting Minutes will be forwarded to the facility's QAPI Committee for review and follow-up for the next twelve months.	

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	required need for hydration in 2 of 3 residents in a sample of 40 observed for dehydration. (Resident #149 & #47) Findings include: 1. On 5-13-13 at 2:34 p.m. Resident #149 was observed to have a dry mouth. On 5-16-13 the resident was observed sleeping with mouth open and breathing thru his mouth. The resident's lower lip was dry with small cracks on lower lip. There was no water pitcher at the bedside or in room for the resident. An interview with LPN#2 on 5-16-13 at 2:45 p.m., indicated the resident was a choking risk and received thicken liquids. LPN #2 stated the resident's fluids are brought to him at 10:00 a.m., 2:00 p.m.,and before bed, daily. The resident also received fluids with his meals. The clinical record of Resident #149 was reviewed on 5-16-13 at 2:55 p.m. The resident's diagnoses included, but were not limited to: depressive disorder, Hemiparesis effecting the dominant side due to cerebrovascular accident (CVA), cognitive			

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	communication deficit, vascular dementia, muscle weakness, aphasia due to CVA. Lab work for 4-13-13, was reviewed and indicated the resident's Blood Urea Nitrogen (BUN) was 25 which was slightly high. Normal range for BUN 8-23. The Careplan review indicated the resident had a potential for alteration in nutrition status/fluid balance related to nectar thick liquids, potential for weight fluctuations related to chronic leg edema, The goal for the resident was to consume adequate fluids/food daily. Interventions included, but were not limited to: monitor food/fluid intake and record daily, weigh per policy, and monitor in Nutritional Risk program as needed. On 5-16-13 at 4:40 p.m., a clinical assessment report-titled "Resident Nutritional Assessment," dated 1-15-13, was reviewed and indicated the resident's estimated nutrient needs were 2350-2820 kcals (calories), 94 grams of protein and 2350-2820 milliliters (ml) of fluid per day. On 5-16-13 at 10:10 a.m. the fluid and snack intake for April 1 thru April			

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	30, 2013 was reviewed and indicated the daily total fluid intake range for fluids was 480 ml to 1273 ml, per day and the percent range for the snack consumed was 0 to 100%. During an interview on 5-16-13 at 10:30 a.m., the DON (Director of Nursing) indicated there were two places that fluids were recorded. The forms titled "Follow Up Question Report," dated 4-1-13 thru 4-30-13, provided by the DON, indicated the fluid intake and snack intake. The DON indicated the snack report did not reflect the amount of milliliters of fluid the resident was receiving each day because it was tracked by percentage of consumption. The snack consisted of 2 fluids with a milliliter amount of 360 ml each. The DON was unable to provide information that confirmed the resident was receiving 2350-2820 milliliters of fluid a day.			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review and interviews, the facility failed to ensure there was adequate monitoring of medications for 2 of 10 residents reviewed for unnecessary medications (Resident #207 and 62). In addition, the facility failed to ensure a psychotropic medication was not increased without attempts at non-pharmacological interventions for 1 of 10 residents reviewed for unnecessary medications. (Resident #116) The facility also failed to	F000329	**F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Facility will continue to ensure that each resident's drug regimen is free from unnecessary drugs. **Corrective Actions:** A Hemoglobin A1C was obtained in April 2013 and will not be due again until October 2013 for resident #62. The facility's contracted lab service has now been scheduled to perform this lab test every six months going forward. The Gradual Dose Reductions (GDRs) recommended by the consultant	06/16/2013

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	ensure a gradual dose reduction of antipathetic medication was attempted for 1 of 10 residents reviewed for unnecessary medications. (Resident #62) Findings include: 1. The clinical record for Resident #62 was reviewed on 05/15/13 at 2:30 P.M. Resident #62 was admitted to the facility on 10/12/07, and readmitted to the facility on 12/19/2011, with diagnoses, including but not limited to, contracture of joints, dysphasia due to cerebrovascular disease, abnormal posture, weakness, hemiplegia due to cerebral vascular accident, anemia, depressive disorder, hyperlipidemia, hypertension, chronic ischemic heart disease, chronic pain syndrome, hypertrophy prostate without ureter obstruction, constipation, diabetes, paralysis agitans, aphasia, vascular dementia with depressed mood, dementia without behaviors, disturbance of conduct- unspecified. Review of the medication orders, for May 2013, for Resident #62 included orders for the following medications to treat the resident's diabetes; Lantus and Humolog insulin and Metformin. In addition, there were physician's		pharmacist on 2/15/13 will be requested, again, with facility utilizing its Medical Director and/or Consultant Pharmacist, as needed, to convince the resident's physician to accept the recommendations. Physician orders obtained for CMP to monitor need and efficacy for furosemide and potassium and TSH and T4 to monitor need efficacy for Levothyroxine. Lab results were obtained and MD made aware of results. All other lab orders for resident 207 remain active. Facility will meet with Consultant Pharmacist, resident #116's wife, and the Behavior Management Team to determine how to proceed with a GDR. It is of note that the 2567 mis-states the situation with the physician's hesitancy to reduce resident #116s medications. Physician indicates that "…every decrease of meds ***beyond this level*** has met with failure and increased distress", to which 2567 responds with "…Nor was the statement at the end of the note correct as the resident had experienced positive outcomes ***to previous gradual dose reductions***". The physician is not disputing that ***previous GDRs*** have been successful but rather that reductions attempted to bring the resident's dosages ***beyond their current level*** have been unsuccessful. **How Others Identified:** All residents requiring behavior management have the potential to be affected by this	

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	orders to check the resident's blood sugar levels twice a day and to obtain a Hemoglobin A1C (blood glucose level) lab test every 6 months. The lab section of Resident #62's paper chart, reviewed on 05/16/13 at 1:30 P.M., indicated the most recent Hemoglobin AIC test result was dated 07/24/12. The resident's results at the time were noted to be elevated at 9.1. The normal range for the lab was between 5.2 - 6.1 mg/dl. Interview with RN #19, on 05/16/13 at 1:30 P.M., indicated she had checked with the laboratory and the lab test, which should have been completed in January 2013 had been missed. In addition, Resident #62 was receiving the antipsychotic medication, Risperdal, and the medication lamotrigine for mood issues, cymbalta for depression and pain issues, and trazodone for depression issues. Review of the Social service notes, dated 5/13/2013 at 13:50 (1:50 P.M.) indicated the following: "... On the PHQ-9 (Minimum Data Set assessment related to mood), he did not have any moods, saying ,he is happy, sleeping OK, told me "What I do I have enough energy. On		alleged deficient practice. **Preventative Measures:** Nursing staff has been in-serviced on the need to attempt non-pharmacological interventions before the initiation or increase of a pharmacological intervention. All efforts will be documented. Nursing staff have been educated and must consult with DON or designee prior to initiating orders for psychoactive medications. All medications have been reviewed for appropriate diagnosis and for labs to monitor need for and efficacy of medication. **Monitoring:** Interdisciplinary Team will review and monitor Behavior logs including interventions 5 x week to ensure appropriate interventions were attempted and medication changes are made only when evidence of need has been documented. These findings will be submitted to the facility's QAPI Committee for review and follow-up. All findings will be discussed in the monthly QAPI Committee meeting for further system review as deemed appropriate by the committee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	05/10/13, he was yelling in the DR [dining room], some confusion noted per staff. He is not followed by [name of psychiatric service] as (physician's name) takes care of all his needs and med's. Wife and (physician's name), talk all the time about this resident about his med's. He is on cymbalta 60 mg [milligrams] for pain, risperdal 0.5 mg BID [twice a day] for behaviors, GDR [gradual dose reduction] on 02/15/13, and trazodone 12.5 mg q [every] hs [bed time] for depression GDR also on 02/15/13. He is also on lamotrigine 25 mg 3 times q am for dementia last GDR on 02/15/13. On 05/10/13, he was yelling in the main DR that [name] baby was under the table. His feet where placed on his foot pedals and he was calm. No evidence of psychoses, delusions or delirium have been noted...." Review of the physician's orders prior to February 15, 2013 and after February 15, 2013, indicated the doses and frequency for the Risperdal, Lamigital, Trazadone, and Cymbalta did not change. Interview with Employee #10, a SSD (Social Service Director), indicated she assumed they did a reduction on 02/15/13, but LPN #20, the Unit Manager, indicated the orders were			

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	discontinued and reentered for the same medications and doses due to adding more specific diagnosis and/or medical symptoms to support the medication use. After researching further, Employee #10, indicated on 05/18/12, the facility had requested a gradual dose reduction and the physician had refused, and in November 2012, the resident's Risperdal medication was changed from an injection form to an oral tablet form, but there had been no attempt at any reductions. There were no continued documentation in the Behavior monitoring forms or in the nursing progress notes of continued behaviors that were not able to be redirected with non-pharmalogical interventions and or were not related to increased pain issues. Review of a pharmacy recommendation 08/16/12, indicated they recommended reducing the Trazadone from 25 mg. The antidepressant medication was reduced to 12.5 mg which is the current dose. 2. The clinical record for Resident #207 was reviewed on 05/16/13 at 10:45 A.M. The resident was			

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	admitted to the facility on 01/03/2013, with diagnosis, including but not limited to, s/p (status post) bacterial pneumonia, influenza, diabetes, hypertension, hypothyroidism, Alzheimer disease, dementia with behavioral disturbances, hypercholesterolemia, macular degeneration of retina, glaucoma, atrial fibrillation, hx (history) of Acute CVA (cerebral vascular accident). The physician orders for Resident #207, current through May 2013, included orders for the diuretic medication, Furosemide, a mineral replacement of Potassium, and a medication to stimulate the thyroid, Levothyroxine. The laboratory orders were for a weekly PT/INR (a test to monitor the viscosity of the blood due to a blood thinning medication), a CBC (counted blood count) ordered to be completed on 05/18/13 and 07/18/13, and an order for a Hemiglobin A1C (a test to check blood sugar control) and a Lipid panel (a test to check for Cholesterol levels). There was no test to monitor the effectiveness of the diuretic and potassium medications, nor was there any test to check for the effectiveness of the thyroid medications. Review of the laboratory test results			

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	section of the clinical record indicated a BMP (Basic metabolic panel), had been completed on 01/07/13, four days after the resident had been admitted. During an interview on 05/16/13 at 9:45 A.M., LPN #11 confirmed there was no thyroid lab ordered. 3. The clinical record for Resident #116 was reviewed on 05/15/13 at 3:45 P.M. Resident #116 was admitted to the facility on 05/13/10, with diagnoses, including but not limited to stiffness of lower leg joint, dysphagia, dyspepsia, depressive disorder, generalized anxiety disorder, chronic pain, constipation, hypertension, chronic ischemic heart disease, paralysis agitans, cardiovascular disease, vascular dementia, and disturbance of conduct. The physician's orders for Resident #116, current through May 2013, included orders for the medications, Divalproex Sodium (an antiseizure medication)125 mg three tablets at bedtime due to dementia and disturbance of conduct diagnoses, Risperdone (an antipsychotic medication) .5 mg at bedtime and .25 mg in the am, and Seroquel (an			

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	antipsychotic medication) 50 mg at bedtime. A pharmacy recommendation, dated 01/29/13, indicated the following: "Review of Social Service notes and nursing notes suggest his last dose reduction attempts were successful: Risperdal was reduced in May 2012, Depakote was reduced in August 2012. No recent behaviors are noted in charting. As his current regimen utilizes 2 antipsychotic agents, and he has had no recent behaviors I would like to attempt to eliminate 1 of these agents, and if any behavioral issues occur, then consider adjusting Depakote dose or addition of an SSRI [Selective Serotonin Reuptake Inhibitor] if behaviors related to his GAD (generalized anxiety disorder). So may we reduce Risperdal to 0.25 mg hs (bedtime) x 2 weeks then reduce to .25 mg am and DC [discontinue] hs dose while leaving Seroquel at 50 mg at hs?" The physician agreed to the recommendation on 02/10/13. Review of the nurses notes and the behavior monitoring records, from 02/10/13 - 03/05/13, indicated there were three behavior issues noted during the time frame. On 02/28/13 from 11:45 - 12:30 P.M., the resident			

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	was noted to be yelling in the hallway and his room. The resident was repositioned, toileted, and music was played, but there was no positive outcome. There were no other ADL's (activity of daily living) attempted at the time. On 03/01/13 at 10:00 A.M., the resident was yelling in the hallway. The resident was taken to the restroom and changed, but there was no documentation as to wether the behavior stopped or continued. On 03/02/13 at 9:30 A.M., the resident was documented to be agitated and yelling out. The resident was placed in bed, his brief changed, then gotten back up in his recliner/wheelchair and the behavior outcome was "positive." A nursing progress notes, regarding the behaviors noted, on 03/02/13 at 9:30 A.M., indicated the following: " This am res. [resident] agitated and yelling out at staff after brief was changed and laying in bed for short period of time. Res. assisted back to w/c [wheelchair] cont. [continued] yelling and scooting self to front of w/c. Res. toileted then assisted to recliner in dayroom. Res. rested in recliner with eyes closed. Wife came in and updated on behaviors this am and assisted him with lunch. No other behaviors noted this shift. (physician's name) informed of behaviors. "			

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A Social Service progress note, dated 03/04/13, indicated the following: " Resident has had 3 behaviors since GDR of risperdal on 02/28,03/01,03/02. DR has been made aware of new behaviors. "

Review of a Physician's progress note, dated 03/05/13 at 17:25 P.M. (5:24 P.M.), indicated the following: "Pt (patient) has had increased behaviors since GDR of Respiradol (sic). He is yelling out more frequently, shower increased agitation, in obvious distress. Wife is also distressed to see him pt obviously uncomfortable will increase respiradone (sic) to previous levels, where pt was much more comfortable. wife agrees. NOTE: every attempt at decrease of meds beyond this level has met with failure and increased distress. I do not see the need to attempt any more GDRs unless pt conditon markedly changes."

There was minimal documentation in the clinical record and behavior documentation to support the increase in the resident's antipsychotic medication as only one negative outcome to nonpharmalocial interventions was documented. Nor

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	was the statement at the end of the note correct as the resident had experienced positive outcomes to previous gradual dose reductions. Finally, it was unclear why the physician did not attempt to follow the pharmacy recommendation to add an SSRI or adjust the Depakote level before increasing the antipsychotic medication. 3.1-28(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)			

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F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interviews, the facility failed to ensure the facility medication error rate was below 5 %. There were 3 medication errors observed out of 33 opportunities for a 9.09 % medication error rate. These included errors for 3 of 8 residents observed receiving medications. (Residents #55, #14 and #180) Findings include: ON 05/13/13 between 9:15 A.M. - 9:25 A.M., LPN #11 was observed to prepare the polyethelene glycol powdered medication for Resident #55. The nurse correctly measured the powdered medication but only mixed the medication with 5 ml (milliliters)of an Antiaging complex and approximately 3 - 4 ounces of cranberry juice. The physician's order for the medication indicated it was supposed to be mixed with 8 ounces of liquid. On 05/16/13 at 10:37 A.M., RN #3 was observed to administer 4 units of Humolog insulin to Resident # 180.	F000332	**F332 MEDICATION ERRORS** Facility will continue to ensure that it is free of medication error rates of 5 percent or greater; and that residents are free of any significant medication errors **Corrective Actions:** Medication Error Reports were filed for each of the medication errors noted in the 2567. Physicians and families were notified of the errors. **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Nurses have been in-serviced on the “Rights” of Medication Administration and the importance of administering insulin within 10 minutes of the start of meal service or to provide and observe resident taking 240cc of juice with insulin administration but not more than 20 minutes prior to start of a meal. **Monitoring:** Nursing Managers will audit insulin administration times five times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 8 months to ensure compliance. Nurse managers will observe administration of medications requiring reconstitution in fluids to ensure that the specific instructions and timelines for	06/16/2013

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	On 05/16/13 at 10:39 A.M., RN #3 was observed to administer 5 units of Humolog to Resident #145. Both residents, #180 and #145, were observed from the time they received their insulin injections until the 11:30 A.M. and neither resident was offered or ate any food or drink. Interview with RN #3, on 05/17/13 at 1:45 P.M., indicated she had to administer the insulin injections at the time observed due to the high number of residents who required insulin on her unit and the fact that she herself had "dining room" duty and had to have all of her insulin's given before she reported to the dining room for the lunch meal. She indicated she also was not concerned regarding giving the insulin's at the earlier time because she "knew" her residents. 3.1-25(b)(9) 3.1-48(c)(1)		administration are being followed. Unit Managers will observe 5 such administrations/week for the first two months, then 3 such administrations/week for the next two months, then 2 such administrations/week for the next 8 months to ensure compliance. Observations will be completed on a unit other than a Unit Manager's own. These findings will be submitted to the facility's QAPI Committee for review and follow-up. All findings will be discussed in the monthly QAPI Committee meeting for further system review as deemed appropriate by the committee.	

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F000356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure the staff posting was current for 1 of 5 days of the survey. (5/13/13) Finding includes:	F000356	**F356 POSTED NURSE STAFFING INFORMATION** Facility will continue to post its staffing information as required by F356. **Corrective Actions:** None **How Others Identified:** No residents have the potential to be	06/16/2013

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	During the initial tour of the facility, conducted on 05/13/13 at 6:45 A.M. the staff posting displayed was dated 05/10/13 The 05/10/13 staff nursing posting remained on the counter across from the receptionist desk from 6:45 A.M. throughout the day on 05/13/13. On 05/17/13 at 1:30 P.M., during an Environmental tour, Employee #15 was made aware of the issue and indicated the posting should have been current. On 05/17/13 at 1:30 P.M., the staffing posting was noted to be for the correct date. 3.1-13(a)		affected by this alleged deficient practice. **Preventative Measures:** Facility changed schedulers on 5/13/13, the first day of the survey. New scheduler was trained before the end of the survey how to post the staffing information to ensure compliance with F356. **Monitoring:** Members of the management team will be responsible to assure that the staffing posting is up-to-date seven days/week. Monday through Friday the responsibility will fall to members of the Admissions staff, whose office is beside the posting. On the weekends, the responsibility will fall to the weekend manager. Management staff will visualize that the posting is up-to-date and document that on audit form. Audit form will be forwarded to the facility's QAPI Committee monthly for review and follow-up.	

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interviews, the facility failed ensure biological's were correctly labeled for 1 of 8 residents observed receiving	F000431	**F431 DRUG RECORDS, LABEL/STORE DRUGS & BILOGICALS** The facility will continue label and store drugs & biologicals in a way that meets	06/16/2013

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	medications. (Resident #55) In addition, the facility failed to ensure medications stored in medication refrigerators on 2 of 3 nursing units were not expired. This potentially affected 2 residents. (Resident #111 and #82) Finding includes: 1. During the medication administration pass, observed on 05/16/13, LPN #11 administered multiple biological supplements. The bottles of capsules and liquids had the brand name, name of the supplement, and a few bottles had a label with the Resident's name and the physician's name. However, there was no label with the dosage instructions on the bottles. Interview with LPN #11, on 05/17/13 at 10:30 A.M., indicated a pharmacy employee had told the facility the biological's only needed to be labeled with the Resident's name and the physician's name. LPN #11 indicated after the medication administration pass, observed on 05/16/13, she had obtained new labeled which could be filled in for biological's indicating the resident's name, physician's name, order date, and dosage instructions for the biological's.		the requirements set for in F431. **Corrective Actions:** The biological noted in the 2567 were labeled in accordance with F431 during the survey. The expired refrigerated medications noted in the 2567 were discarded during the survey. **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Nurses and QMAs have been inserviced on the need to label biologicals when they arrive at the facility and to routinely dispose of expired medications. **Monitoring:** In addition to the monthly QA check completed by the pharmacy, DON (or designee) will conduct regular checks of the medication carts, refrigerators, and any other place where medications may be stored (i.e. med rooms) to ensure that all medications are labeled properly, including biolgoicals, and that expired medications are discarded. Said checks will be completed weekly for the first two months, bi-weekly for the next 4 months, and monthly for the next six months with results of the checks being forwarded to the facility's QAPI Committee for review and follow-up.	

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	2. During observation of the medication storage room for the Cedars unit, conducted on 05/17/2013 at 2:43 P.M., two large bottles of liquid Omeprazole suspension medication for Resident #111 were noted in the refrigerator. One of the bottles with only approximately 1/4 left was noted to have expired on 05/02/13. The other bottle, which was 3/4 full, was noted to have expired on 05/13/13. Interview with LPN #16, on 05/17/13 at 2:44 P.M., indicated she did not know if the expired Omeprazole liquid were the only bottles for Resident #111. She indicated she was going to remove the bottles. During observation of the medication storage room for the Birch unit, conducted on 05/17/13 at 2:50 P.M., a bottle of Mary's Magic mouthwash solution, for Resident #82 was noted in the medication refrigerator. The bottle, which was full and unopened, was noted to expire on 04/10/13. 3.1-25(j) 3.1-25(k) 3.1-25(l)			

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COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F000492 SS=B	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Based on record review and interview the facility failed to ensure that 1 of 1 residents requesting a demand bill was not charged during the pending decision. (Resident #109) Findings include: On 5/15/13 at 9:15 A.M., record review for Resident #109 indicated, "Form No. CMS-10055 entitled Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)." Last covered day 11/3/12. On the bottom of the left corner of the form it was indicated that the ABN was mailed to the POA (Power of Attorney) on 11/1/12. The form was not signed. On 5/15/13 at 9:30 A.M., interview with the Business Office Manager indicated, "The ABN was mailed to the POA on 11/1/12, when the POA received the ABN he called the facility and asked that we bill a demand claim, and did not return a signed copy of the ABN."	F000492	**F492 COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD** The facility will continue to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. **Corrective Actions:** As noted in the 2567, resident #109 was issued a bill showing that the charges had been reversed on 5/7/13, the week before the survey. **How Others Identified:** All residents requesting a “Demand Bill” have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Business Office Manager was made aware of the “Demand Bill” Policy after the incident occurred but prior to the survey commencing. The rest of the Medicare IDT will be trained on the policy. **Monitoring:** The Medicare IDT will review all “Demand Bills” in process as a regular part of its weekly meeting	06/16/2013

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	On 5/15/13 at 9:45 A.M., review of the Individual Claim Review Skilled Nursing Facility-Demand Bill indicated, "...The payment dates 11/04-11/30/12. Decision: Deny. The decision to deny this claim is based on the following: Documentation supports the beneficiary or authorized representative did not sign the ABN or SNF notice of non-coverage on or before the date of denial of services, or these dates of service (If the notice was not given timely, and the provider is liable for a portion of the DOS being reviewed until the beneficiary or authorized representative sign the notice of non-coverage) (CMS Publication 100-4, Chapter 30)...." On 5/15/13 at 10:00 A.M., review of a statement dated 12/1/12 indicated, "Room and board charges Nov 4-30 2012 $6,399.00." A statement dated 5/1/13 indicated, "Room and board charges Dec 1-4 2012 $948.00." On 5/15/13 at 10:15 A.M., review of the current "Demand Billings" policy received from the Business Office Manager indicated, "...If a resident disputes a facility's conclusion that the billed services are not covered in the Medicare program, the resident has a right to insist that the facility		to ensure that charges, billing, and ongoing treatments are in compliance with the facility's policies on "Demand Bills". In the case that a "Demand Bill" is requested in the next year, the Medicare IDT will complete a checklist/audit that certifies that the appropriate procedures were follows. These checklists/audits will be forwarded to the facility's QAPI Committee for review and follow-up for the next 12 months.	

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	submit a demand bill to the intermediary to confirm that such services are or are not covered. (Note: During the time this decision is pending, the facility will not require, request, or accept an advance deposit or other payment for the disputed item(s).)...." On 5/15/13 at 11:15 A.M., an interview with the Business Office Manager indicated, the final statement that was sent to the POA on 5/7/13 indicated a bad debt write off for the amount of $7452.70, this was a refund for the charges from 11/4/12 through 12/4/12, while the demand bill was pending. 3.1-13(r)(1)			